STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		15E281	B. WING			04/18/2	011
NAME OF F	ROVIDER OR SUPPLIEF	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					EVENTH ST		
GOSPOF	RT NURSING HOM	E		GOSPC	DRT, IN47433		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0000							
	This visit wa	as for a	F0	000			
	Recertificati	ion and State					
	Licensure su	arvey. This visit					
	resulted in a	•					
	survev-imm	ediate jeopardy.					
	Survey IIIIII	ediate jeoparay.					
	Survey dates	s: April 4-8, 2011					
	_	rvey dates: April					
		•					
	14-18, 2011						
	Facility num	nber: 000409					
	Provider nui	mber: 15E281					
		er: 100291270					
	Anvi numoc	51. 100291270					
	Survey team	ı [.]					
	_						
		near, RN, TC					
	Mary Weyls	s, RN 4/4-8/11					
	Census bed	type:					
	NF: 47	~ ^					
	Total: 47						
	C						
	Census paye	• •					
	Medicaid: 4	14					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOKX11

Facility ID:

000409

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MULTIP A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIEF		27	S SE	DDRESS, CITY, STATE, ZIP CODE EVENTH ST PRT, IN47433	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	Other: 3						
	Total: 47						
	Sample: 12 Supplement						
	state finding	encies also reflect ss cited in with 410 IAC 16.2.					
	Quality review com Cathy Emswiller Rl						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI A. BUII		INSTRUCTION 00	(X3) DATE S COMPL	ETED
		15E281	B. WIN			04/18/2	011
	PROVIDER OR SUPPLIER		•	27 S SE	ADDRESS, CITY, STATE, ZIP CODE EVENTH ST DRT, IN47433		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	DATE
F0156 SS=C	The facility must in orally and in writing resident understand all rules and regular conduct and responsive facility. The faresident with the number of admission and durn Receipt of such information amendments to it, writing. The facility must in entitled to Medicaid time of admission when the resident Medicaid of the ite included in nursing State plan and for be charged; those that the facility offer resident may be of charges for those are resident when charand services speciand (B) of this second (B) of this second in the facility must in or at the time of action available in the facility in the	afform the resident both g in a language that the ads of his or her rights and ations governing resident ansibilities during the stay in cility must also provide the otice (if any) of the State (1919(e)(6) of the Act. Such the made prior to or upon a ming the resident's stay. Formation, and any must be acknowledged in the state of the nursing facility or, becomes eligible for and services that are gracility services under the which the resident may not other items and services and for which the narged, and the amount of services; and inform each neges are made to the items affied in paragraphs (5)(i)(A) tion. Inform each resident before, dimission, and periodically it's stay, of services for ed under Medicare or by the market.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/18/2011				
	PROVIDER OR SUPPLIER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION			
	procedures for est Medicaid, including assessment under control of the control of	rces at the time of and attributes to the an equitable share of annot be considered ent toward the cost of the rouse's medical care in his spending down to Medicaid s, addresses, and s of all pertinent State client such as the State survey gency, the State licensure inbudsman program, the rocacy network, and the introl unit; and a statement may file a complaint with the certification agency in abuse, neglect, and of resident property in the compliance with the advance ments. I comply with the cified in subpart I of part 489 atted to maintaining written dures regarding advance requirements include in and provide written indult residents concerning or refuse medical or and, at the individual's an advance directive. This description of the facility's ent advance directives and						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15E281 04/18/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 27 S SEVENTH ST **GOSPORT NURSING HOME** GOSPORT, IN47433 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. The corrective action 05/18/2011 Based on observation and interview, the F0156 accomplished for those residents facility failed to display written found to have been affected by information concerning Medicare and the deficient practice is the Medicaid benefits. This had the potential posting of information concerning Medicare and Medicaid and how to affect 47 of 47 residents residing in the to apply. Residents having the facility. potential to be affected by the same deficient practice are all Finding includes: residents residing in the facility. Measures put into affect to ensure the practice does not During observation on 4/8/11 which recur is weekly observance of the began at 11:00 a.m., with Maintenance bulletin board where the staff #15, posting of information information is posted by the concerning Medicare and Medicaid Social Services Director.The Social Services Director will information was not noted. monitor the bulletin board weekly to make sure the information is During interview of the Social Service still posted. If not, she will Designee [SSD] on, 4/8/11 at 3:00 p.m., replace the information posted. The Social Services the [SSD] indicated the facility did not Director will report findings at the have information concerning Medicare monthly QA meeting. and Medicaid posting. The [SSD] was unable to provide a written policy concerning the posting. 3.1-4(1)(1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/18/2011	
NAME OF B	AN OLUBER OR GURRI HER	100201	B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	0471072011
	PROVIDER OR SUPPLIER RT NURSING HOME	-		EVENTH ST DRT, IN47433	
				JR 1, 11147433	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F0164 SS=D	The resident has the and confidentiality clinical records. Personal privacy in medical treatment, communications, promeetings of family this does not requiprivate room for each except as provided section, the resident the release of personal and clinic when the resident health care institut required by law. The facility must kninformation contain records, regardles methods, except witransfer to another	he right to personal privacy of his or her personal and includes accommodations, written and telephone personal care, visits, and and resident groups, but re the facility to provide a ach resident. If in paragraph (e)(3) of this int may approve or refuse sonal and clinical records to	F0164	The corrective accomplishme for this deficient practice will inservice all staff on privacy and procedure. Those reside identified to be affected by the deficient practice include all residents of the facility. All residents have the potential affected as all residents recesome type of personal care to	ent be to policy ents are to be ive
				staff.Steps to correct the defi practice will be to inservice a	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE: COMPL 04/18/2	ETED	
	ROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE EVENTH ST PRT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	record revie	servation and w, the facility vide personal			staff on privacy issues. Residents will be asked if the feel they have privacy at all the when ADLs and injections are done. Residents will be asked the monthly resident council meetings with responses recorded. The corrective act will be monitored by the Administrator and DON who review the responses made resident council meetings. Should there be a negative response, the DON shall spewith that resident and identifiarea of lack of privacy. DON then speak with the staff me identified as not following the policy and procedure and the staff member shall then be inserviced again. The reside will be asked about privacy fronsecutive meetings without complaint regarding privacy issues, then at random meet therefore. The DON and chain urses shall be responsible to observe weekly for compromin privacy issues by observing residents who cannot speak themselves during ADL times. This weekly observation shall a staff. Observations shall be documented and reported at monthly QA meetings times months.	times eed at tion will at the eak y the I will mber eat ents or 2 ut a tings rge to nises ng for s. II be nd	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E281		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 04/18/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	privacy to 1	of 1 resident						
	observed du	ring incontinence						
	care in a san	ple of 12 and 3 of						
	4 residents o	bserved receiving						
	insulin injec	tions in a sample of						
	12. [Resider	nts #3, #21, #14						
	and #25]							
	Findings inc	lude:						
	CNAs #1 an to provide in Resident #3. assisted to the bedroom. We open to the heathroom do #3 was assisted front of the seathroom. The and soiled in the seathroom in the seathroom.	oor open, Resident ted to stand in sink in the he resident's slacks acontinence brief ed and incontinence						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281			LDING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED	
	PROVIDER OR SUPPLIER		p. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE EVENTH ST ORT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	2. On 4/6/11	1 at 11:15 a.m.,					
	LPN #3 was	observed to					
	*	nsulin injection to					
		1. Resident #21					
		d in bed in her					
	room, and th						
		as observed seated					
		the opposite side					
		Privacy was not					
	maintained of	· ·					
	administration						
		as the privacy					
		not pulled, and					
		re in full view of					
	each other.						
	3 During m	edication pass on,					
		30 a.m., LPN #6					
		rt of Resident #25					
	and provided						
	1	e LPN did not pull					
	"	s privacy curtain					
		lent's roommate					
		on the side of his					
		g with Resident					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281			LDING	NSTRUCTION 00	CON	TE SURVEY MPLETED 8/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433					
	#25. 4. During many segulatory or 4/5/11 at 11: lifted the shi and provided injection. The pull the privare resident's room the side of Resident #14 A facility po "Privacy," do provided by 4/7/11 at 10: but was not in the pull that the privare side of the privare side of the privare side of the side of	ratement of deficiencies cy must be perceded by full lsc identifying information) edication pass on, 45 a.m., LPN #3 rt of Resident #14 d an Insulin he LPN did not acy curtain and the ommate was sitting of his bed facing 4.	B. WIN	STREET A	EVENTH ST	CODE RRECTION SHOULD BE	(X5) COMPLETION DATE	
	privacy at al care, privacy to room to b Grooming, b (unless an ac invasive pro	I timesDuring curtain and door e closed. eathing, nail care,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281	(X2) MU A. BUIL B. WING	LDING	00	(X3) DATE S COMPL 04/18/2 (ETED
	ROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0221 SS=D	drops, nose so G-Tube feed administration meds may be group setting are not discussion are not discussion and discussion are not discussion are not discussion are not discussion and discussion are not discussion are not discussion and discussion are not discus	ne right to be free from any imposed for purposes of nience, and not required to medical symptoms. Servation, and record review, ailed to release the mes outlined in the for 1 of 2 residents the physical a sample of 12.] indes:	FO	221	The corrective action accomplished for this deficier is inservicing staff on restrain use, especially on when to release the restraint. Those residents identified as having potential to be affected by the deficient practice are those residents of the facility with restraint orders. Steps to correct the deficient practice will be to inservice nursing staff on poli restraint use including releas restraint. The corrective action be monitored by the charge nurses and DON as they will observe residents in restraint during mealtimes and family and document that the restra was released. If the resident	ect to icy of ing n will ts visits	05/18/2011

i		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15E281	1	LDING	00	COMPLET 04/18/201	
		102201	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 17 10720 1	' '
NAME OF I	PROVIDER OR SUPPLIER				EVENTH ST		
	RT NURSING HOME	≣		1	DRT, IN47433		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE (COMPLETION DATE
-		was observed in			restrained during mealtime, t		
the dining room, in a				resident will be inserviced again at that time. All physician orders			
	wheelchair v	vith a lap buddy			were audited by the DON on		
	restraint on l	peing fed by LPN			28 and 29 for inaccurate orders. Physicians were notif		
	#12.				of any incorrect orders and restraint orders are now corre		
	On 4/5/11 at	10·20 a m			on resident orders.The charg nurses and DON will be	je	
		was observed			responsible for monitoring th corrective action daily for 2	e	
					months. If the deficiency is		
		heelchair with lap			observed during the last mor		
	buddy on in	lounge area. The			the observations will be extended for another month, until one	naea	
	resident's hu	usband was seated			month is free of deficiencies.		
	next to the re	esident. On 4/5/11			will report findings at the mor QA meetings.	nthly	
	at 11:15 a.m	., Resident #3 was					
	observed in	the activity/dining					
	room in a wl	neelchair with a lap					
	buddy on.						
	Dunin - ala	mystism of					
	During obse						
		administration,					
		ed Resident #3 if					
	she was able	to remove the lap					
	buddy. Resi	dent #3 appeared					
	to understand the question but						
	physically was unable to						
		device. During					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E281		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 04/18/2	LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433					
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	interview at	that time, LPN #6	ĺ					
indicated she had never known								
	of the reside	nt removing the						
	device.							
	Resident #3'	s clinical record						
	was reviewe	d on 4/4/11 at 2:30						
	p.m. The res	sident's diagnoses						
	included, bu	t were not limited						
	to Huntingto	n's Chorea.						
	assessment, 11/9/10 code	Data Set [MDS] completed on ed the resident as estraint daily.						
	Form," compindicated the	l "Restraint Audit oleted on 4/7/11, e resident utilized a straint due to very						
	little muscle	control due to Huntington's						
	_	e form indicated						
	bed and chai	r alarms had been						
	tried as less	restrictive methods						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED		
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	which result	ed in the resident						
	getting up ur	nassisted and staff						
	unable to get	t to the resident						
	quick enough	h which resulted in						
	and updated the problem Lap Buddy v chair for per approach incl lap buddy du	e on ones, and						
	recapitulatio physician 4/ documentati utilizing a pe	cent physician's n, signed by the 1/11 included the on of the resident elvic or soft posey revent injury to						
	On 4/7/11 at	3:10 p.m. the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281			(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SUR COMPLETE 04/18/201	ED
NAME OF I	PROVIDER OR SUPPLIEI	 	STREET	ADDRESS, CITY, STATE, ZIP COL)E	
GOSPO	RT NURSING HOM	E		SEVENTH ST PORT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE C	(X5) OMPLETION DATE
	DON was in	nterviewed. The				
	DON indica	ted a physician's				
	order for the	e lap buddy was				
	lacking.					
	3.1-26(b)					
	3.1-26(r)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15E281	B. WING		04/18/2011
	PROVIDER OR SUPPLIER		27 S SE	ADDRESS, CITY, STATE, ZIP CODE EVENTH ST DRT, IN47433	
				7(1, 1147 400	•
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
F0225		ot employ individuals who	IAG		DAIL
SS=J	have been found or mistreating resinate had a finding nurse aide registry mistreatment of resortheir property; a has of actions by a employee, which we service as a nurse	guilty of abusing, neglecting, dents by a court of law; or gentered into the State y concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for a aide or other facility staff to de registry or licensing			
	violations involving abuse, including ir and misappropriat reported immediat the facility and to with State law through	msure that all alleged g mistreatment, neglect, or njuries of unknown source ion of resident property are sely to the administrator of other officials in accordance ough established procedures tate survey and certification			
	alleged violations	ave evidence that all are thoroughly investigated, further potential abuse while in progress.			
	reported to the adding representative and accordance with S State survey and ownsking days of the violation is verified action must be take				
	Based on int	erview and record	F0225	The corrective action accomplished for this deficie	05/18/2011
	·	facility failed to		includes the following: Inservicing of all employees	
	report to the	Administrator or		abuse as well as any new hin before they start work; initiati	res

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE SUR COMPLETI		
		15E281	A. BUI B. WIN	LDING IG		04/18/201 ²	1
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	EVENTH ST		
GOSPOI	RT NURSING HOM	E		GOSPC	ORT, IN47433		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re C	OMPLETION DATE
	DON immed				an abuse reporting form for t	he	
		imely allegations			reporting of allegations with inservicing of all staff on the	new	
	1	nent expressed			form; inservicing of activity director on reporting abuse a	ınd	
	during Resid	dent Council			resident council notes by the social service consultant;		
	meetings for	2 of 7 months of			monitoring of CNA's by the		
	council min	utes reviewed and			charge nurses for any abuse updating policies on resident		
	through staf	f interviews.			council minutes to read "min will be given to administrator		
	Residents #	431, #11, #48,			DON, and department heads	;	
	#45,#21, #1	8 and #441			before the end of the day of		
	" 10," = 1, " 1	o, and //]			meeting." Residents having to potential to be affected by the		
					deficient practice are all resid		
	This deficien	nt practice resulted			of the facility.Measures put in		
	in Immediat	e Jeopardy. The			place to ensure the deficient practice does not recur inclu-		
	immediate j	eopardy was			the inservicing of all employed on abuse, initiating an abuse	es	
	identified or	n 4/14/11 and began			reporting form, updating police		
	on 1/26/11.	The Director of			reporting of resident council minutes. Skin assessments	were	
	Nursing, So	cial Service			done on all residents on Apri	l 14,	
	Designee, ar	nd Administrator			2011, with no suspicious or unknown findings. All alert a	nd	
	were notifie	d of the Immediate			oriented residents were interviewed on April 14, 2011	,	
	Jeopardy on	4/14/11. The			regarding abuse or roughnes staff. Each month, a random	s by	
	Immediate J	eopardy was			selection of residents/familie		
	removed on	4/18/11, but the			be contacted by staff and as about resident treatment.	ked	
	facility rema	ained out of			Interviews to be documented		
	compliance at the level of no				The allegations toward the the CNA's (7, 9, and 13) were		
	actual harm with potential for more than minimal harm that is			investigated and found to be unsubstantiated, however, a			
				CNA's are no longer employ			
					at this facility.Administrator a	nd	

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	` ′	ATE SURVEY MPLETED
MDILM	or conduction	15E281	A. BUII		00		8/2011
			B. WIN				
NAME OF F	PROVIDER OR SUPPLIER				EVENTH ST		
	RT NURSING HOME			GOSPO	PRT, IN47433		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL)	ION D BE	(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRODEFICIENCY)		DATE
	not immediate jeopardy				Social Service director s responsible to make sure		
	because on g	going in-service			Resident's Council minu	es are	
	_	taff and new hires			given to the administrato and department heads the		
	regarding im	plementation of			the meeting is held. Administrator will be resp	onsible	
	new abuse re	eporting procedure			to see that all allegations		
	will continue				abuse are investigated IMMEDIATELY by him or his		
	continued m	onitoring to ensure			designee.		
	policy is being	ng followed.					
	Investigation	n of allegations					
	regarding Cl	NAs #7, #9 and					
	#13 to be co	mpleted and					
	implementat	ion of remedies					
	dependant or	n outcome of					
	investigation	ns as well as					
	reporting to	ISDH outcome of					
	investigation	ns. Monitoring of					
	the Activity	Director in regard					
	to reporting	allegations					
	immediately	to the					
	Administrato	or/DON and					
	providing Re	esident Council					
	Minutes to tl	he Administrator,					
	DON, and S	SD, the day of the					
	council meet	tings will continue					
	by the Admi	nistrator and SSD.					
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	TOKX11	Facility I	D: 000409 If continua	tion sheet	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	COMPI		
		15E281	B. WIN			04/18/2	011
NAME OF I	PROVIDER OR SUPPLIER	2	·	1	ADDRESS, CITY, STATE, ZIP CODE	•	
GOSPOF	RT NURSING HOMI	Ε		1	EVENTH ST DRT, IN47433		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		raining of the AD					
	will continue	e with the Social					
	Service Con	sultant. On going					
	monitoring of	of residents through					
	interviews o	f them or their					
	representativ	yes to be done on a					
	monthly bas	is through a system					
	of staff assig	gned to specific					
	residents.						
	Findings inc	lude:					
	1. Resident	council meeting					
	minutes, we	re reviewed on					
	4/4/11 at 2:1	0 p.m. The					
	minutes date	ed 1/26/11,					
	included in 1	new business:					
	Resident #3	1 said he had					
	complaints a	about CNAs #7, #9,					
	and #13 loud	dly complaining it					
		e job to clean					
		when they had "s-					
	_	hemselves in front					
		#31 and other					
	residents. R						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPI		
		15E281	B. WIN	LDING IG		04/18/2	011
NAME OF I	PROVIDER OR SUPPLIEF	* }	•		ADDRESS, CITY, STATE, ZIP CODE	•	
GOSPOR	RT NURSING HOM	E		1	EVENTH ST DRT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	indicated CN	NA #7 called him a					
	slob one day	and "gets in					
	peoples' face	es" when talking to					
	them and Cl	NA #13 argues with					
	him. The mi	nutes indicated					
	Residents #4	48 and #45					
	witnessed th	e same.					
	Resident #48	8 no longer resides					
	in the facilit	y and Resident #45					
	was not able	to be interviewed					
	due to a cyc	lic event related to					
	diagnoses of	f Schizoaffective					
	disorder, Bij	polar.					
	The DON w	as interviewed on					
	4/4/11 at 3:0	00 p.m. The DON					
	indicated sh	e had not been					
	made aware	of the allegations					
	from the me	eting. The DON					
	indicated it i	is the Activity					
	Director [AI	O's] responsibility					
	to report im	mediately to the					
	Administrate	or/ DON any					
	allegations e	expressed during					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	the council r	neetings, and						
	minutes of the	ne meeting are to						
	be provided	to the						
	Administrate	or, DON and						
	department l	neads no later than						
		er the meeting. The						
	DON indicate	ted this was not						
	being done.							
	p.m. The Ac	on 4/14/11 at 2:55 dministrator had not been made						
	reviewed on included, bu to, in new bu #31 indicate the same and CNA make I	utes dated 2/22/11, 4/4/11 at 2:10 p.m. t was not limited usiness, Resident d things continue the had seen a Resident #11 cry the is a trouble						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281			ILDING	00	COMPI 04/18/2	LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
	DON providinvestigation regarding the CNA making The report wand indicated identified] by allegation to days after the meeting. The investige documented Resident #11 Resident #11 general about and was asked any staff methim cry. The no. The resist specifically as	her attention six e resident council ative report interviews of and LPN #12. I was questioned in at staff treatment ed specifically if mbers had made e resident indicated dent was asked about ff members by						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MU A. BUIL B. WING	LDING	NSTRUCTION 00	(X3) DATE COMF 04/18/	LETED	
	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE EVENTH ST PRT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	indicated no	·					
	DON on 4/5, the DON indinterviewed provides rest and spends ropen common Resident #11 the time. The the resident from in from one time as a stating "help other resident television shoresident begat LPN indicate witnessed and the time and the time in the resident begat LPN indicate witnessed and the time in the time.	LPN #12 as she torative services most of day in the on area where spends most of the LPN indicated had been removed to f the television was repeatedly and disrupting into the watching a tow and the an crying. The ed she had not try kind of abusive intertace treatment of					
		t 3:05 p.m., I was interviewed.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		15E281	B. WIN			04/18/20	011
NAME OF F	PROVIDER OR SUPPLIER		-	1	ADDRESS, CITY, STATE, ZIP CODE		
GOSPOF	RT NURSING HOME	≣		1	EVENTH ST DRT, IN47433		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΤE	COMPLETION DATE
	The resident	indicated the CNA					
	who made R	esident #11 cry					
	was CNA #7	7. Resident #31					
	indicated the	e CNA was					
	repeatedly te	elling Resident #31					
	he was diabe	etic and the resident					
	became upse	et and was crying.					
	Resident #31	I indicated he had					
	not been inte	erviewed regarding					
	the incident.						
	Resident #31	l's clinical record					
	was reviewe	d on 4/8/11 at 2:00					
	p.m. The M	inimum Data Set					
	[MDS] asses	ssment, completed					
	on 2/22/11 c	oded the resident					
	with no cogr	nitive or memory					
	problems.	J					
	1						
	Resident #11	was interviewed					
	on 4/14/11 a	t 3:20 p.m. The					
		cated everything					
	was fine.						
	Resident #11	's clinical record					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPLI 04/18/20	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	was reviewe	d on 4/15/11 at						
	1:00 p.m. T	he resident's						
	diagnoses in	cluded, but were						
	not limited to	o, dementia,						
	personality of	lisorder,						
		mpulsive disorder						
	_	epression. The						
		Minimum Data Set						
	[MDS] asses	•						
		reference date of						
		I the resident with						
	a score of 12	-						
	impairment]							
	3. On 4/14/1	1 staff members						
	were intervie	ewed beginning at						
	1:00 p.m. Ci	NA #5 indicated						
	Resident #18	8 had voiced a						
	concern of C	CNAs #7 and #13						
	[2 of 3 CNA	s identified in						
	January Resi	ident Council						
	meeting] bei	ng rough during						
	care. CNA #	\$5 indicated the						
	resident repo	orted it to her						
	shortly after	the CNAs began						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE EVENTH ST DRT, IN47433		
	employment [November, indicated yo to the nurse, remember if 4. CNA #1 v The CNA increported sev CNA #17, w weekends, w providing ca indicated she the nurse, an with it.	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) in the facility 2010]. The CNA u would report this but could not		27 S SE	EVENTH ST	E	(X5) COMPLETION DATE
	thinks CNA identified in Council mee during care,	#9 [1 of 3 CNAs January Resident eting] is rough and was rough erring Resident #8					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED	
	PROVIDER OR SUPPLIER		p. wnw	STREET A	ADDRESS, CITY, STATE, ZIP CODE EVENTH ST DRT, IN47433		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	5. CNA #8 ii	ndicated he was					
	working with CNA #7 and						
	Resident #21	I requested he					
	cleanse her s	skin during care, as					
	CNA #7 was	s too rough.					
	on 4/14/11 a indicated she	I was interviewed t 3:15 p.m. and e had no concerns eatment or care					
	DON provid of an intervi- Resident #22 Resident #22 had been rou was cleaning not do it deli- resident poir stopped and since then.	has been okay 'He is too much of n, doesn't know his					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE IDENTIFICATION NUMBER: A. BUILDING B. WING		LDING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED		
	PROVIDER OR SUPPLIEF		•	27 S SE	DDRESS, CITY, STATE, ZIP CODE EVENTH ST DRT, IN47433	•	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	ETATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	#7 to transferough. He be 2 to 3 weeks he had report The docume DON's resid completed or interview of interview, in limited to, C in bed too has transferred residents and was rough we residents and #44, #40, and Resident #46 indicated Resident #46 indi	8 did not like CNA er her as he was too elieved it was about a ago and he thinks eted it to a nurse. Intation of the ent interviews in 4/14/11 included a Resident #18. The included but was not end when he has me." Interviewed and when he has me." Intation of the ent interviews in 4/14/11 included a Resident #18. The included but was not end when he has me." Interviewed and when he has me." Interviewed and when he has me."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281			LDING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	EVENTH ST DRT, IN47433	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	and CNA #7	would get close to					
	his face and	tell the resident the					
	bugs would	get on his face and					
	in his mouth	when he was					
	sleeping. Th	ne CNA indicated					
		6 looked frightened					
		y. The CNA					
	indicated the incident occurred						
	in January and the resident						
	refused to sl	eep in his room for					
	four nights a	and slept in another					
	room.						
	The DON w	as interviewed on					
	4/14/11 at 4:	00 p.m. The DON					
	indicated sho	e was aware					
	Resident #46	6 was afraid of					
	bugs and CN	VA #7 had stripped					
	the resident's	s bed and "gone					
	through the	motions of					
	spraying the	room for bugs" in					
	an attempt to	relieve the					
	resident's fea	ar. The DON					
	indicated she	e was not aware of					
	any allegation	on of staff trying to					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E281		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	CO	ate survey Mpleted 8/2011			
	PROVIDER OR SUPPLIER		<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CEVENTH ST PRT, IN47433	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN			SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PERCEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	scare the res	ident.							
	was reviewed 11:05 a.m. Indiagnoses in not limited to disorder, chreencephalopa brain injury A nurse's not 6:00 a.m. was [resident] has of noc [night that there are bed-have trisleep in anot success." A 2/11/11 7 am the resident of there were specified that the specified that	thy from traumatic and hallucinations. te dated 2/11/11 at as noted of Res s been awake most t,] is convinced e spiders in Res ed to get him to ther room without nurse's note dated and performed saying piders everywhere. Its room was a the resident							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		ĺ	LDING	NSTRUCTION 00	(X3) DATE COMP 04/18/2	LETED	
NAME OF	PROVIDER OR SUPPLIE	R		1	ADDRESS, CITY, STATE, ZIP CODE		
GOSPO	RT NURSING HOM	1E		1	EVENTH ST DRT, IN47433		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
	continued saying there were						
	spiders ever	rywhere.					
	A nursing n	ote dated 2/12/11 at					
	6:00 p.m. w	as noted of "Res					
	[resident] ha	as continuously					
	talked about spiders all day.						
	He has stomped on imaginary						
	spiders, picked them off of						
	himself, flipped them across						
	the table. R	an fast up to the					
	nurses' stati	on and said the					
	spiders were	e going to his heart.					
	Can reorien	t res after a time					
	and it will la	ast for a short					
	while." Doc	rumentation of the					
	behavior reg	garding spiders was					
	continued o	n nurses' notes					
	dated 2/13/1	11 and 2/14/11.					
	Documenta	tion on 2/15/11 at					
	6:00 a.m. in	dicated the resident					
	walked the	halls until 3:00 a.m.					
	at that time	he said there were					
	bugs, bugs	, bugs in his bed."					
		on East and got in					
							1

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
THETETAL	or connection	15E281	A. BUILDING B. WING		04/18/2011
NAME OF I	ADOLADED OF CLASH IED			ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIER		I	EVENTH ST	
GOSPORT NURSING HOME				DRT, IN47433	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
	other bed, sl	ept until 5:00 a.m.			
	CNA #9 indi	icated CNA #7			
	"deliberately	yanks" the lift			
	sling out from	m under Resident			
	#44 which re	esulted in a skin			
	tear to the le	ft elbow two			
	months ago.				
	The CNA in	dicated the			
		or and DON had			
		d of incidents, but			
		· ·			
	_	stopped reporting			
	in January b				
	Administrato				
	weren't doin	g anything.			
	The DON w	as interviewed on			
	4/14/11 at 4:	00 p.m. The DON			
		e did not know of			
	any skin tear	rs to Resident #44			
		lent was assessed			
	oy woulld ac	octor weekly.			
	D 1	4			
	Kesiaent #44	4 was interviewed			
				l	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281		(X2) MU A. BUII B. WIN	LDING	ONSTRUCTION 00	(X3) DATE S COMPL 04/18/2	ETED	
	VIDER OR SUPPLIER		•	27 S SE	ADDRESS, CITY, STATE, ZIP CODE	ı	
	NURSING HOME		_		DRT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
О	on 4/15/11 a	t 3:00 p.m. and					
iı	ndicated he	did not have any					
c	oncerns wit	h the way he was					
tı	reated.						
R	Resident #44's clinical record was reviewed on 4/15/11 at						
v							
1	10:53 a.m. A Minimum Data						
S	Set [MDS] assessment, with						
a	ssessment r	eference date of					
2	2/8/11 coded	the resident with					
n	no memory o	or cognitive					
iı	mpairments	and required total					
a	ssistance of	two for transfers					
a	and total ass	istance of one for					
h	ygiene/bath	ing.					
	A /1 A /1 4						
		at 4:10 p.m., the					
	•	ed documentation					
		Training Class					
	_	d 12/31/10 for					
	•	esidents with					
	-	ting Co-Workers					
V	vith Respect	t, Reporting					
A	Abuse." A p	ere and post test					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED	
NAME OF I	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	0 11 1012	
GOSPOR	RT NURSING HOME	Ξ		GOSPC	DRT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	sample prov	ided with the					
	attendance s	heet addressed					
	"Treating Re	esidents With					
	Respect," an	d reporting abuse					
	immediately	to the charge					
	nurse. Revie	ew of the inservice					
	documentati	on indicated CNAs					
	#8, #5, #1, and #9 attended the						
	in-service. Documentation of						
	the AD attending was lacking.						
	On 4/7/11 at	12:30 p.m., the					
	[AD] Activit	ty Director,					
	responsible t	for taking minutes					
	in the Reside	ent council					
	meetings, in	dicated she makes					
	copies of the	e meetings' minutes					
	and gives on	e to the DON, the					
	SSD [Social	Service Designee]					
	and puts a co	opy in a book of					
	council minu	ites. The AD					
	indicated it i	s not done					
	immediately	, but usually a					
	couple of da	ys later.					
	The facility's polic	y titled "Abuse Policy," [no					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		15E281	B. WING			04/18/2	011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		T	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
TAG	date] reviewed on included, but was Resident Abuse Popersons shall imm supervisor of staff being involved, Thand/or Administration and family or responsified within 24 high period of time in winvestigation is be involved staff mensuspended from dof said investigation, tho to exceed 72 high Board of Health with will be the involved A policy titled "Pol Resident's Counciby the DON on 4/5, but not limited to, given to the admindepartment heads following the meet mistreatment or attimmediately to the head."	4/5/11 at 10:15 a.m. not limited to, "Staff to olicy: 1.) The following lediately be notified: i person suspected of the Director of Nursing stor, Attending Physician, onsible party of resident. Board of Health shall be shours. 4.) During the which the in house ling done, the alleged line will be temporarily uty pending the outcome on. 5.) At the conclusion of the time frame of which is lours, the Indiana State lill be notified of results, as did persons" licy and Procedure for I, dated 6/20/10, provided will the minutes shall be		TAG	DEFICIENCY)		DATE
		4/14/11 at 2:30					
	*	nmediate Jeopardy					
		26/11 in that the					
	facility failed	d to report					
	allegations o	f verbal abuse					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E281			LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/18/2011	Y	
	PROVIDER OR SUPPLIER		D. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE EVENTH ST DRT, IN47433		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	TE COMI	(X5) PLETION ATE
	expressed du	ring Resident					
	Council mee	etings immediately					
	to the Admir	nistrator/DON and					
	through staff	finterviews					
	allegations r	egarding rough					
	treatment du	ring care and					
	intimidation	were not reported					
	immediately	to the					
	Administrator/DON and						
	investigation	ns done or					
	thoroughly is	nvestigated. The					
	Administrato	or, DON, and SSD					
	were notified	d of the Immediate					
	Jeopardy on	4/14/11 at 2:30					
	p.m. related	to failure to report					
	allegations o	of verbal abuse					
	immediately	to the					
	Administrato	or/DON and					
	investigation	ns done, or					
	thoroughly is	nvestigated.					
	The Immedia	ate Jeopardy was					
	removed on	April 18, 2011,at					
	3:30 p.m., w	hen through					
	observations	, interview and					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	NSTRUCTION 00	COMP	SURVEY LETED	
		15E281	B. WIN			04/18/2	2011
NAME OF I	PROVIDER OR SUPPLIER	* }	•	1	DDRESS, CITY, STATE, ZIP CODE	•	
GOSPOR	RT NURSING HOM	E	27 S SEVENTH ST GOSPORT, IN47433				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		
TAG	· `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
	record revie	w it was					
	determined 1	that the facility had					
	implemented the plan of action						
	to remove th	ne Immediate					
	Jeopardy and	d that the steps					
		red the immediacy					
	1 *	em. Through					
	observation, 2 of 3 CNAs with						
	allegations of verbal abuse or						
	rough handl	ing were suspended					
	pending invo	estigation and 1 of					
	3 CNAs, on	days worked, was					
	·	y assigned nurses					
	pending con	npletion of					
	investigation	n. Nurses were					
	assigned shi	fts for continued					
	monitoring of	of all staff as well					
	as the DON.	A new policy					
	regarding ab	ouse reporting to					
	ensure allega	ations are reported					
	immediately	to the					
	Administrate	or/DON was					
	developed a	nd inservice					
	training star	ted on 4/18/11.					
	The Activity	Director was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	te survey Ipleted 3/2011	
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP EVENTH ST DRT, IN47433	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	in-serviced r	regarding the Abuse				
	policy and p	rocedure, as well				
	as training re	egarding providing				
	Resident Co	uncil Minutes to				
		trator, DON, and				
		y of the meetings.				
		vice Consultant				
	began additi	onal training of the				
	AD on 4/18/	11. All staff were				
	re-inserviced	d regarding the				
	facility's abu	se policies and				
	procedures.	Even though the				
	facility's cor	rective action				
	removed the	IJ, the facility				
	remained ou	t of compliance at				
	a reduced sc	ope and severity				
	level of no a	ctual harm with				
	potential for	more than minimal				
	harm that is	not immediate				
	jeopardy.					
	3.1-28(c) 3.1-28(d))					
	3.1-20(u))					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281			(X2) MU A. BUILI B. WING	DING	00	COMPL 04/18/2	ETED		
GOSPOF	PROVIDER OR SUPPLIER RT NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE		
F0226 SS=J	written policies and mistreatment, neg and misappropriate Based on intreview, the freport to the DON immediately investigate to	evelop and implement d procedures that prohibit ect, and abuse of residents on of resident property. erview and record acility failed to Administrator or liately and mely allegations ent expressed	F02	226	The corrective action accomplished for this deficient includes the following: Inservicing of all employees abuse as well as any new hir before they start work; initiation abuse reporting form for the reporting of allegations with inservicing of all staff on the form; inservicing of activity director on reporting abuse a	on res ng he	05/18/2011		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPL	
111,212,11	or confidence.	15E281	A. BUI B. WIN	LDING		04/18/2	
			D. WIN		DDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF	PROVIDER OR SUPPLIEI	₹		1	EVENTH ST		
GOSPO	RT NURSING HOM	E		GOSPO	PRT, IN47433		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION DATE
		dent Council			resident council notes by the social service consultant;		BINE
	meetings for 2 of 7 months of						
	1	utes reviewed and			monitoring of CNA's by the charge nurses for any abuse updating policies on resident		
		f interviews.			council minutes to read "min	utes	
	_	² 31, #11, #48,			will be given to administrator DON, and department heads		
	-				before the end of the day of		
	#45,#21, #1	8, and #44]			meeting." Residents having t		
					potential to be affected by the deficient practice are all residuals.		
	This deficie	nt practice resulted			of the facility.Measures put in		
		e Jeopardy. The			place to ensure the deficient		
		1 2			practice does not recur inclu- the inservicing of all employe		
	1	eopardy was			on abuse, initiating an abuse		
	identified or	n 4/14/11 and began			reporting form, updating police		
	on 1/26/11.	The Director of			reporting of resident council minutes. Skin assessments	were	
	Nursing, So	cial Service			done on all residents on Apri		
	1	nd Administrator			2011, with no suspicious or unknown findings. All alert a	ınd	
	1	d of the Immediate			oriented residents were	ii i d	
					interviewed on April 14, 2011		
	1 1	4/14/11. The			regarding abuse or roughnes staff. Each month, a random		
	Immediate J	eopardy was			selection of residents/familie	s will	
	removed on	4/18/11, but the			be contacted by staff and asl about resident treatment.	ked	
	facility rema	ained out of			Interviews to be documented		
	compliance	at the level of no			The allegations toward the the CNA's (7, 9, and 13) were	ree	
	1 -	with potential for			investigated and found to be		
		ninimal harm that is			unsubstantiated, however, all CNA's are no longer employed		
					at this facility.Administrator a	ind	
	not immedia				Social Service director shall	be	
	because on a	going in-service			responsible to make sure Resident's Council minutes a	are	
	training of s	taff and new hires			given to the administrator, D	ON,	
					and department heads the da	ay	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPL		
		15E281	A. BUI B. WIN	LDING IG		04/18/2	011
NAME OF I	PROVIDER OR SUPPLIER	!!		1	ADDRESS, CITY, STATE, ZIP CODE		
GOSPOF	RT NURSING HOMI	≣		1	EVENTH ST DRT, IN47433		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
1/10		plementation of		1710	the meeting is held. Administrator will be respon		DATE
		eporting procedure					
		e, as well as,			to see that all allegations of abuse are investigated IMMEDIATELY by him or hi		
		onitoring to ensure			designee.	5	
		ng followed.					
	1	n of allegations					
	regarding Cl	NAs #7, #9 and					
	#13 to be completed and implementation of remedies						
	dependant of	n outcome of					
	investigation	ns as well as					
	reporting to	ISDH outcome of					
	investigation	ns. Monitoring of					
	the Activity	Director in regard					
	to reporting	allegations					
	immediately	to the					
	Administrate	or/DON and					
	providing Re	esident Council					
	Minutes to the	he Administrator,					
	DON, and S	SD, the day of the					
	council mee	tings will continue					
	by the Admi	nistrator and SSD.					
	Additional to	raining of the AD					
	will continue	e with the Social					
	Service Con	sultant. On going					

NAME OF PROVIDER OR SUPPLIER B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST	
GOSPORT NURSING HOME GOSPORT, IN47433	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY	(X5) COMPLETION DATE
CROSS-REFERENCED TO THE APPROPRIATE	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MU A. BUII B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED	
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE EVENTH ST		
GOSPOF	RT NURSING HOMI	E		GOSPC	DRT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	them and CN	NA #13 argues with					
him. The minutes indicated							
	Residents #4	48 and #45					
	witnessed th	e same.					
	in the facility was not able due to a cycl diagnoses of disorder, Bip	8 no longer resides y and Resident #45 to be interviewed lic event related to f Schizoaffective polar. as interviewed on					
		0 p.m. The DON					
		e had not been					
	made aware	of the allegations					
	from the me	eting. The DON					
	indicated it i	s the Activity					
	Director [AI	O's] responsibility					
	to report im	mediately to the					
	Administrate	or/ DON any					
	allegations e	expressed during					
	the council r	neetings, and					
	minutes of the	he meeting are to					
	be provided	to the					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE S COMPLI	
		15E281	A. BUI B. WIN			04/18/20	011
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE EVENTH ST	•	
GOSPOF	RT NURSING HOME	Ē		1	DRT, IN47433		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Administrato	or, DON and					
	department heads no later than						
	*	er the meeting. The					
	DON indicat	ted this was not					
	being done.						
	The Adminis						
		on 4/14/11 at 2:55					
	p.m. The Ac						
		had not been made					
	aware of the	allegations.					
	2. The Resid	dont agunail					
		utes dated 2/22/11,					
		4/4/11 at 2:10 p.m. t was not limited					
	ĺ						
	ŕ	isiness, Resident					
		d things continue I he had seen a					
		Resident #11 cry					
	_	ne is a trouble					
	maker over a	iliu ovei.					
	 On 4/5/11 at	10:15 a.m., the					
		ed a report of an					
	P20 (16						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E281			LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	investigation	she had done					
regarding the allegation of a							
	CNA making	g Resident #11 cry.					
	The report w	as, dated 2/28/11					
		d a resident [not					
	identified] b	-					
		her attention six					
	days after th	e resident council					
	meeting.						
	The investigative report documented interviews of Resident #11 and LPN #12. Resident #11 was questioned in general about staff treatment and was asked specifically if any staff members had made him cry. The resident indicated no. The resident was specifically asked about different staff members by name, and the resident indicated no.						
	During an in	terview with the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281			LDING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	3	(X5) COMPLETION DATE
	DON on 4/5	/11 at 10:15 a.m.,					
	the DON indicated she						
	interviewed	LPN #12 as she					
	provides rest	torative services					
	and spends r	nost of day in the					
	•	on area where					
		spends most of					
		e LPN indicated					
	the resident had been removed						
	from in from	t of the television					
	one time as v	was repeatedly					
	stating "help	" and disrupting					
	other resider	nts watching a					
	television sh	ow and the					
	resident bega	an crying. The					
	LPN indicate	ed she had not					
	witnessed an	y kind of abusive					
	or inappropr	iate treatment of					
	the resident.						
	On 4/14/11 a	at 3:05 p.m.,					
	Resident #31	was interviewed.					
	The resident	indicated the CNA					
	who made R	esident #11 cry					
	was CNA #7	. Resident #31					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE: COMPL 04/18/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
	indicated the	e CNA was						
	repeatedly te	elling Resident #31						
	he was diabetic and the resident							
	became upse	et and was crying.						
	Resident #31	I indicated he had						
	not been inte	erviewed regarding						
	the incident.							
	was reviewe p.m. The M [MDS] asses on 2/22/11 c	d's clinical record d on 4/8/11 at 2:00 inimum Data Set ssment, completed oded the resident nitive or memory						
	on 4/14/11 a	was interviewed t 3:20 p.m. The cated everything						
	was reviewe 1:00 p.m. T	l's clinical record d on 4/15/11 at he resident's cluded, but were						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	E	(X5) COMPLETION DATE
	not limited to	o, dementia,					
	personality of	disorder,					
	obsessive/compulsive disorder						
	and major de	epression. The					
	most recent	Minimum Data Set					
	[MDS] asses	ssment, with					
	assessment r	reference date of					
	3/1/11 coded the resident with						
	a score of 12	? [moderate					
	impairment]	•					
	were intervied 1:00 p.m. Cl. Resident #18 concern of Cl. [2 of 3 CNA January Resident representation of Cl.	1 staff members ewed beginning at NA #5 indicated 8 had voiced a 2NAs #7 and #13 s identified in ident Council ng rough during #5 indicated the orted it to her the CNAs began in the facility 2010]. The CNA u would report this					

Facility ID:

PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPI	2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED O4/18/2011	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281	
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) to the nurse, but could not (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE: PROVIDENT FLAND OF CORRECTION COMPTION	STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST		
	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION COMPLETION THE APPROPRIATE	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX
remember if she had.		to the nurse, but could not	
		remember if she had.	
4. CNA #1 was interviewed. The CNA indicated she had reported several times that CNA #17, who only works weekends, was rough when providing care. The CNA indicated she had reported it to the nurse, and the nurse dealt with it. CNA #1 also indicated she thinks CNA #9 [1 of 3 CNAs identified in January Resident Council meeting] is rough during care, and was rough when transferring Resident #8 from the wheelchair to geri-chair. 5. CNA #8 indicated he was working with CNA #7 and Resident #21 requested he		4. CNA #1 was interviewed. The CNA indicated she had reported several times that CNA #17, who only works weekends, was rough when providing care. The CNA indicated she had reported it to the nurse, and the nurse dealt with it. CNA #1 also indicated she thinks CNA #9 [1 of 3 CNAs identified in January Resident Council meeting] is rough during care, and was rough when transferring Resident #8 from the wheelchair to geri-chair. 5. CNA #8 indicated he was working with CNA #7 and	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED
	PROVIDER OR SUPPLIER		•	27 S SE	DDRESS, CITY, STATE, ZIP CODE EVENTH ST DRT, IN47433	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	cleanse her s CNA #7 was	skin during care, as s too rough.					
	on 4/14/11 a indicated she	1 was interviewed t 3:15 p.m. and e had no concerns eatment or care					
	DON provide of an intervent Resident #2. Resident #2. had been rown was cleaning not do it deliveresident point stopped and since then.	at 3:40 p.m. the led documentation iew completed with 1 on 4/14/11. I indicated CNA #7 agh once when he g her up, but did iberately. The nted it out, it has been okay "He is too much of an, doesn't know his n."					
	CNA #8 also Resident #18	o indicated 8 did not like CNA					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIER		P. W.	STREET A	ADDRESS, CITY, STATE, ZIP CODE EVENTH ST DRT, IN47433	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	#7 to transfe	r her as he was too					
	rough. He be	elieved it was about					
	2 to 3 weeks	ago and he thinks					
	he had repor	ted it to a nurse.					
	DON's resid completed of interview of interview, in limited to, C	ntation of the ent interviews n 4/14/11 included Resident #18. The cluded but was not NA #7 "has put me ard when he has					
	6. CNA #9 v The CNA incomes was rough was rough was rough was rough was residents and #44, #40, and Resident #46 indicated Revery afraid coand CNA #7 his face and	vas interviewed. dicated CNA #7 with certain d named Residents d doesn't like					

l	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMP 04/18/	LETED
	PROVIDER OR SUPPLIER		27 S SE	ADDRESS, CITY, STATE, ZIP CO EVENTH ST DRT, IN47433	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	in his mouth	when he was				
	sleeping. Th	ne CNA indicated				
		6 looked frightened				
		y. The CNA				
		e incident occurred				
	-	nd the resident				
		eep in his room for				
	four nights a	and slept in another				
	room.					
	4/14/11 at 4: indicated she Resident #46 bugs and CN the resident's through the spraying the an attempt to resident's fea indicated she	of was afraid of NA #7 had stripped is bed and "gone motions of room for bugs" in the relieve the far. The DON is was not aware of on of staff trying to				
	Resident #40	6's clinical record				

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281	A. BU	ILDING	00 	COMPI 04/18/2	LETED
		100201	B. WI		DDDECC CITY CTATE ZID CODE	J 07/10/2	
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
GOSPOF	RT NURSING HOME	<u> </u>			PRT, IN47433		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	was reviewe	d on 4/15/11 at					
	11:05 a.m. 🛚	The resident's					
	diagnoses in	cluded, but were					
	not limited to	o, chronic mood					
	disorder, chr	ronic					
	encephalopa	thy from traumatic					
	brain injury	and hallucinations.					
	A nurse's note dated 2/11/11 at						
	6:00 a.m. wa	as noted of Res					
	[resident] ha	s been awake most					
	of noc [night	t,] is convinced					
	that there are	e spiders in Res					
	bed- have tri	ed to get him to					
	sleep in anot	ther room without					
	success." A	nurse's note dated					
	2/11/11 7 am	n-7 p.m. indicated					
		continued saying					
		oiders everywhere.					
	The resident						
	cleaned ever	the resident					
	helped but th						
	_	ying there were					
	spiders every	•					
	_	,					

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO. LDING	00		COMPL	
		15E281	B. WIN				04/18/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATEVENTH ST	ΓE, ZIP CODE		
GOSPOF	RT NURSING HOME	<u> </u>		1	ORT, IN47433			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX		AN OF CORRECTION E ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCEI DEFIG	D TO THE APPROPRIAT CIENCY)	E	DATE
	_	ote dated 2/12/11 at	ĺ					
	6:00 p.m. wa	as noted of "Res						
	[resident] ha	s continuously						
	talked about	spiders all day.						
	He has stom	ped on imaginary						
	spiders, pick	ed them off of						
	himself, flip	ped them across						
	the table. Ra	an fast up to the						
	nurses' static	on and said the						
	spiders were going to his heart.							
	Can reorient	res after a time						
	and it will la	st for a short						
	while." Doci	umentation of the						
	behavior reg	arding spiders was						
	_	n nurses' notes						
	dated 2/13/1	1 and 2/14/11.						
	Documentat	ion on 2/15/11 at						
	6:00 a.m. inc	dicated the resident						
		alls until 3:00 a.m.						
	at that time l	ne said there were						
		bugs in his bed."						
		on East and got in						
		ept until 5:00 a.m.						
	, -							
	CNA #9 indi	icated CNA #7						
FORM CMS-2	567(02-99) Previous Version	ns Obsolete Event ID:	TOKX11	Facility I	ID: 000409	If continuation sh	leet Pa	ge 54 of 102

PRINTED: 05/23/2011 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED
	PROVIDER OR SUPPLIER		p. w.i.v.	STREET A	DRT, IN47433	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	"deliberately	yanks" the lift					
	sling out fro	m under Resident					
	#44 which re	esulted in a skin					
	tear to the le	ft elbow two					
	months ago.						
	been notified	or and DON had d of incidents, but stopped reporting ecause the or and DON					
	4/14/11 at 4: indicated she any skin tear and the resid	as interviewed on 00 p.m. The DON e did not know of rs to Resident #44 lent was assessed octor weekly.					
	on 4/15/11 a indicated he	4 was interviewed t 3:00 p.m. and did not have any the the way he was					

Facility ID:

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMP	
		15E281	A. BUI B. WIN	LDING IG		04/18/2	2011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
	RT NURSING HOMI			1	EVENTH ST PRT, IN47433		
(X4) ID		TATEMENT OF DEFICIENCIES		ID I			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	treated.						
	Resident #44 was reviewed 10:53 a.m. A Set [MDS] as assessment in 2/8/11 coded no memory of impairments assistance of and total assistance of and total assistance/bath On 4/14/11 as DON provide of Inservice Report, date "Treating Respect Treating Respect Treati	and required total f two for transfers istance of one for ning. at 4:10 p.m., the led documentation Training Class d 12/31/10 for esidents with ating Co-Workers t, Reporting ore and post test ided with the heet addressed					
	Treating Re	esidents With					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281		LDING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED
	PROVIDER OR SUPPLIER		p. wiiv	STREET A	ADDRESS, CITY, STATE, ZIP CODE EVENTH ST DRT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Respect," an	d reporting abuse					
	immediately	to the charge					
	nurse. Review of the inservice						
	documentation indicated CNAs						
	#8, #5, #1, a	nd #9 attended the					
	in-service. D	Occumentation of					
	the AD atten	ding was lacking.					
	On 4/7/11 at	2 4/7/11 4 12 20 41					
	On 4/7/11 at 12:30 p.m., the [AD] Activity Director,						
		•					
	•	for taking minutes					
	in the Reside						
	•	dicated she makes					
	*	e meetings' minutes					
	_	e to the DON, the					
	-	Service Designee]					
	-	opy in a book of					
		ites. The AD					
	indicated it i						
		, but usually a					
	couple of da	ys later.					
	date] reviewed on included, but was Resident Abuse Po	y titled "Abuse Policy," [no 4/5/11 at 10:15 a.m. not limited to, "Staff to olicy: 1.) The following lediately be notified:					

STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			JLTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLE	ETED
		15E281	B. WING			04/18/20)11
	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE EVENTH ST DRT, IN47433		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
IAU	supervisor of staff being involved, The and/or Administrate and family or responder The Indiana State in notified within 24 It period of time in with investigation is beinvolved staff mensuspended from dof said investigation, the investigation of the alth with will be the involved. A policy titled "Police Resident's Counciby the DON on 4/5 but not limited to, given to the admindepartment heads following the meet mistreatment or at immediately to the head." An Immediately to the head." An Immediately to the head."	f person suspected of the Director of Nursing tor, Attending Physician, consible party of resident. Board of Health shall be thours. 4.) During the which the in house sing done, the alleged on the will be temporarily duty pending the outcome con. 5.) At the conclusion of the time frame of which is cours, the Indiana State will be notified of results, as did persons" Ilicy and Procedure for all, dated 6/20/10, provided with at 10:15 a.m., included, "The minutes shall be anistrator, DON, and no later than 2 days ting. Any allegations of course shall be reported administrator/department at Europardy was 4/14/11 at 2:30 anmediate Jeopardy 26/11 in that the did to report		IAU	Dia Kilanci I		DAIE
	_	of verbal abuse					
	expressed du	ring Resident					
	Council meetings immediately						
	to the Admir	nistrator/DON and					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281	(X2) MULT A. BUILDIN B. WING		00	(X3) DATE S COMPL 04/18/2	ETED
	PROVIDER OR SUPPLIER		2	7 S SE	DDRESS, CITY, STATE, ZIP CODE VENTH ST RT, IN47433	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	through staff	finterviews					
		egarding rough					
		ring care and					
		were not reported					
	immediately						
	Administrato						
	investigation						
		nvestigated. The					
		or, DON, and SSD					
		d of the Immediate					
	1	4/14/11 at 2:30					
	•	to failure to report					
		of verbal abuse					
	immediately						
	Administrato						
	investigation	, and the second					
	thoroughly i	nvestigated.					
	removed on 3:30 p.m., w observations record review determined to	s, interview and					

Facility ID:

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281			LDING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE EVENTH ST DRT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	to remove th	e Immediate					
Jeopardy and that the steps							
	taken remov	ed the immediacy					
	of the proble	em. Through					
	observation,	2 of 3 CNAs with					
	allegations o	of verbal abuse or					
	rough handli	ing were suspended					
	pending inve	estigation and 1 of					
	3 CNAs, on	days worked, was					
	monitored by	y assigned nurses					
	pending com	pletion of					
	investigation	n. Nurses were					
	assigned shift	fts for continued					
	monitoring of	of all staff as well					
	as the DON.	A new policy					
	regarding ab	use reporting to					
	ensure allega	ations are reported					
	immediately	to the					
	Administrato	or/DON was					
	developed as	nd inservice					
	training start	ted on 4/18/11.					
	The Activity Director was						
	in-serviced r	egarding the Abuse					
	policy and procedure, as well						
	as training re	egarding providing					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIER			27 S SE	DDRESS, CITY, STATE, ZIP CODE EVENTH ST DRT, IN47433	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
		uncil Minutes to					
		trator, DON, and y of the meetings.					
		vice Consultant					
	began additi	onal training of the					
		11. All staff were					
		d regarding the					
		se policies and Even though the					
	-	rective action					
		IJ, the facility					
		t of compliance at					
		ope and severity					
		ctual harm with more than minimal					
	•	not immediate					
	jeopardy.						
	3.1-28(a)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING B. WING 00				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
F0253 SS=D	maintenance serving a sanitary, orderly Based on obserview, the ensure resident maintained if geri-chairs a buddies observipped or had [Residents # Findings inc.]	nd 2 of 3 lap erved were either d bent frames. 9, #42, and #8]	F0253	The corrective action accomplished for this deficie is that 2 new geri-chairs and buddies will be ordered to re the damaged ones. Those residents having the potenti be affected by the deficient practice are identified as the residents who use a geri-ch lap buddy. Measures put into place to ensure the deficien practice does not recur is st be inserviced on monitoring geri-chairs and lap buddies wear and damage and how report to maintenance if rep are needed. Maintenance winspect geri-chairs weekly a document findings and report administrator when repairs/replacements are	d 3 lap eplace al to ose air or ot aff will for to airs vill nd		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281	A. BUILDING B. WING		00	(X3) DATE COMPI 04/18/2	LETED
NAME OF	PROVIDER OR SUPPLIER	3	-	1	ADDRESS, CITY, STATE, ZIP CODE EVENTH ST	-	
GOSPO	RT NURSING HOM	E		GOSPC	DRT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
TAG	with the Ma on 4/8/11 at Resident #9 observed wirest. Maint looked under during intermindicated the foot rest was 12:00 p.m., observed in dining room footrest to bright. 2. During of on 4/5/11 at Resident #4 geri-chair. Chair was observed and position work way. The visione corner of the corner	intenance staff #15 11:00 a.m. Is geri-chair was th a crooked foot enance staff #15 or the chair and view at that time e metal frame to the s bent. On 4/4/11 at Resident #9 was the chair, in the or and for the e slanting to the		TAG	needed.Administrator will be responsible for geri-chair replacement/repairs and D be responsible for replaced damaged lap buddies.	oe ON will	DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281		(X2) M ¹ A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 04/18/2	ETED	
	PROVIDER OR SUPPLIER			27 S SE	DDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ON SHOULD BE COMPLETIC	
	Heavy dust	was noted on the					
	interior back	base of the					
	geri-chair.						
	Resident #8 wheelchair wacross her abovering of too observed with	at 11:20 a.m., was in a with a lap buddy odomen. The vinyl the lap buddy was th three torn areas white foam interior.					
F0315 SS=D	assessment, the faresident who enter indwelling cathete the resident's clinic that catheterization resident who is incappropriate treatmurinary tract infect normal bladder fur Based on ob interview, and	·	F0	315	The corrective action accomplished for the reside found to have been affected the deficient practice is inservicing of staff on foley		05/18/2011
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID:	TOKX11	Facility I		sheet Pa	ge 64 of 102

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	15E281	A. BUII		00	COMPLETED 04/18/2011
		100201	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	04/10/2011
NAME OF F	PROVIDER OR SUPPLIER			1	EVENTH ST	
	RT NURSING HOME	≣		1	DRT, IN47433	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
		n a urinary drainage			catheter care/placement.Residents ha	
	catheter in a manner to prevent				the potential to be affected b same deficient practice are	- I
	back flow ar	nd potential for			identified as those resident w	vith a
	infection for	1 of 2 residents			foley catheter. (4)Measures prints place to make sure the	out
	reviewed in	a sample of 12.			deficient practice does not re	cur
	[Resident #4	1]			is inservicing staff on proper catheter care and checking or	off
					each nursing staff member fo	or
	Finding inclu	udes:			knowledge of proper cathete placement. The charge nurse	I
	8				and DON will monitor the	
	On 4/5/11 at	3:15 p.m., CNAs			corrective action by observat daily of catheter care/placem	
		•			with documentation on flow	
		ere observed to			sheets. Daily observations to done for 30 days, then week	I
	•	and transfer			30 days. DON will review	
	Resident #41	I from the bed to			infection control log monthly increase in UTI with foleys.	for
	wheel chair	with a mechanical			moreage in our war loleye.	
	lift. Residen	nt #41 was				
	observed wit	th an indwelling				
		er. Amber colored				
	_	erved in the				
	drainage bag	g and tubing.				
	 While position	oning a sling under				
	•	CNA #8 placed				
	•	•				
	_	Irainage on the				
	· ·	xt the resident.				
	CNA #8 then	n raised the				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPI		
		15E281	A. BUI B. WIN	LDING IG		04/18/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	•	
GOSPOF	RT NURSING HOMI	≣		1	EVENTH ST DRT, IN47433		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		g and tubing,		TAG	DEFICIENCY)		DATE
		•					
		ove the resident					
		while CNA #7					
		om to retrieve an					
	item.						
	D 11 . 114	11 11 1 1					
		l's clinical record					
		d on 4/6/11 at 3:30					
	-	ost recent Minimum					
	_	DS] assessment,					
	completed o	n 1/25/11 coded					
	the resident	as utilizing a Foley					
	catheter. A p	physician's order					
	was noted da	ated 3/4/11 for an					
	antibiotic to	treat a urinary tract					
	infection.						
	A facility po	licy titled "Foley					
	Catheter Car	e," [no date]					
		the DON on 4/7/11					
	_	., included, but was					
		o, "8. Drainage					
		t be raised higher					
	_	es or bladder."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/18/2011		
	RT NURSING HOME		•	27 S SE	DDRESS, CITY, STATE, ZIP CODE VENTH ST RT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE.	(X5) COMPLETION DATE
		view on 4/8/11 at					
	• ′	e SSD indicated					
	CNA #8 had indicated to her						
		ervation that he					
		uld not have raised					
		bag and tubing					
	above the resident's bladder						
level.							
	3.1-41(a)(2)						
F0322 SS=D	a resident, the faci resident who is fed gastrostomy tube i treatment and serv pneumonia, diarrh metabolic abnorma	ulcers and to restore, if					
	Based on ob	servation and	F0:	322	The corrective action accomplished for the residen	.	05/18/2011
	record review	w, the facility			found to have been affected		
	failed to ensi	ure services to			the deficient practice is inservicing of nursing person		
	prevent aspin	ration pneumonia			regarding having the head of bed up at least 30 degrees on residents with g-tube		
	for 1 of 1 res	sident reviewed					
	receiving me	ng medication through a feedings.Residents identified having the potential to be affected having the potential to be affected.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	15E281	1	LDING	00	04/18/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				EVENTH ST	
GOSPOF	RT NURSING HOME	₫		GOSPC	ORT, IN47433	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
	gastrostomy	tube in a sample of			by this deficiency are resider	
	12, in that medication and				with g-tubes. (1)Measures pu into place to make sure the	
	water flushe	s were observed to			deficient practice does not re is inservicing staff on g-tube	ecur
	be given wh	ile the resident was			policy which includes having of bed up. For this resident,	
	lying flat in	bed. (Resident #3)			head of her bed has been ra	ised
					30 degrees and is in a perma fixed position. Also, policy a	•
	Finding incl	udes:			d to	
					reflect 30 degrees instead of degrees, as 30 is much more	e
	During medi	ication pass on			comfortable for resident. The corrective action will be mon	I
	4/6/11 at 2 p	.m., LPN #3			by the charge nurses with da documentation on the Medica	-
	provided me	dication and water			Administration Record under	
	flushes throu	igh a gastrostomy			"HOB raised at least 30 degrees". DON will monitor	the
	tube to Resid	dent #3. The			MAR monthly for the documentation.	
	resident was	lying in bed. The			documentation.	
	head of the b	ped was flat.				
	During the n	nedication and				
	water flushe	s the resident				
	would sit pa	rtially up but at				
	1	ing flat in the bed.				
	1	d not attempt to				
		dent's upper body				
		11				
	positioned 30 degrees or					
	higher.	ier.				
	During review of the facility					
	During revie	w of the facility				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/18/2011
	PROVIDER OR SUPPLIER		27 S SE	ADDRESS, CITY, STATE, ZIP CODE EVENTH ST DRT, IN47433	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	"Administra Through G- identified as	rocedure, titled tion of Medication Tube" received and a current policy			
	Nursing) on a.m., docum but was not resident in p "a. If resider head of bed 3.1-44(a)(2)	N (Director of 4/7/11 at 10:30 entation indicated, limited to, "Place roper position" and at is in bed, elevate to 45 degrees."			
F0323 SS=E	environment rema hazards as is poss receives adequate devices to prevent Based on ob review and i facility failed accidents and accidents for reviewed eit	servation, record nterview, the d to prevent d/or potential c 3 of 3 residents	F0323	1. The electric hoyer lift that bent was removed from facil 4/5/2011 and a new electric lift was purchased and in the facility on 4/5/2011. Mainten to inspect the lift per manufacturer's recommenda and should anything be foun be unsatisfactory, the lift will be used. Facility has a back-up manual lift.3 and 4: corrective action accomplish for this deficiency is inservice.	ity on hoyer end of the

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/18/2011		
		102201	B. WIN		DDDDGG GWW GWW GW GG	10-7/10/2	V11
NAME OF F	PROVIDER OR SUPPLIER	1			DDRESS, CITY, STATE, ZIP CODE		
GOSPOF	RT NURSING HOMI	E		1	PRT, IN47433		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION
IAG		during the use of a	-	TAG	nursing staff on correct use		DATE
					lift.Residents identified as h	•	
	mechanical lift (Residents #'s				the potential to be affected deficient practice are those		
	r r	42) and 1 of 1			residents requiring use of h	oyer	
	resident utili	izing a lap belt			lift for transfers. (11)Praction into place to ensure the def		
ı	restraint (Re	esident #34) in a			practice does not recur incl		
	`	,			the inservicing of nursing st	aff on	
	sample of 12				proper use of hoyer lifts. E		
	manufacture	ers'			staff member will be checked on proper use of lift. Charge		
	recommendations were not				nurses shall be responsible		
	followed during use of mechanical lifts and/or a lift				monitoring the use of the he		
					lifts on their shifts. They sh daily pick one transfer to m		
					and document observations		
	was utilized	after the structure			flow sheet. This shall be da	•	
	had been im	paired. This had			times one month, weekly times		
	· ·	to affect 11 of 11			months, and monthly times months. Findings shall be	3	
	•				reported to the DON and		
	residents uti	lizing mechanical			administrator.2. The correct		
	lifts; and ma	nufacturer's			action accomplished for this deficiency is inservicing of	5	
	recommenda	ations for			nursing staff on correct		
	application of				application of lap restraint.	4:-14-	
		re not followed for			Residents having the poter be affected by the deficient		
					practice are those residents	s with	
		ent reviewed in a			orders for lap restraints. Currently there are no resident	lents	
	sample of 12	2 utilizing the			with orders for lap restraint	as	
	device. (Res	ident #34)			order for lap belt for resider has been dc'd. To ensure the		
	,	•			deficient practice does not	_	
	 Eindings ins	ludo:			is the inservicing of staff on		
	Findings inc	riude.			proper application of lap restraints. Should an order I	20	
					obtained for a resident to h		
	1. During ir	nitial tour on 4/4/11			lap restraint, the charge nu	rse	
					shall monitor daily for prope	er	
FORM CMS-2	.567(02-99) Previous Version	ons Obsolete Event ID:	TOKX11	Facility I	D: 000409 If continuation	sheet Pa	ge 70 of 102

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 15E281		A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE EVENTH ST DRT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	Е	(X5) COMPLETION DATE
TAG	which began with LPN#6, mechanical I hallway with not to use the During interwith LPN #6 11:30 a.m., I there had be the lift on Su LPN indicate	at 12:15 p.m., , an Invacare lift was noted in the n a sign indicating e lift. view on 4/5/11, 6, which began at LPN #6 indicated en an incident with anday, 4/3/11. The ed the lift had during the transfer		TAG	application and document flow sheet findings.	on a	DATE
	(Director of at 12:15 p.m indicated CN the CNAs tra#21. During inter on 4/5/11 at	view of the DON Nursing) on 4/5/11 ., the DON NA #'s 2 and 7 were ansferring Resident view of CNA #2, 12:30 p.m., the red the main mast					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	e survey pleted /2011	
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP EVENTH ST DRT, IN47433	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
		are lift being used				
	to transfer R	esident #21 on				
	· ·	bent. The CNA				
	indicated the	e lift had been bent				
	for a few mo	onths.				
	on 4/7/11 at CNA indicate mast was been and the lift to the left. The the resident as the resident as the resident and landed of the buttocks arms and leg. The CNA in sent out, but mast was still indicated the	view of CNA #7, 2:20 p.m., the red the Invacare lift and toward the left, sipped over toward a CNA indicated thad not been hurt, and grabbed a red the wheelchair on the cushion with and the resident's as were straight out. The CNA are maintenance andicated the lift was the maintenance andicated the lift was the lift was the maintenance andicated the lift was the lift				

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281			LDING	00	COMPI 04/18/2	ETED	
NAME OF I	PROVIDER OR SUPPLIE	 	P. WII		DDRESS, CITY, STATE, ZIP CODE		
	RT NURSING HOM			1	EVENTH ST PRT, IN47433		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
IAG		rview of LPN #3 on		IAG			DAIL
	1	:50 p.m., the LPN					
		e staff knew the lift					
	had a bent n	nast. The LPN					
	indicated, th	ne lift had been used					
	to lift Resid	ent #40 off the					
	floor and that	at was when the lift					
	was damage	ed. The LPN					
	indicated sh	e thought they had					
	sent the lift	out to be fixed and					
	when the lif	t was returned, they					
	were told th	e lift was safe to be					
	used. The I	LPN indicated the					
	mast of the	lift on return was					
	still bent.						
	During inter	view of the					
	Maintenanc	e supervisor on					
	4/7/11 at 11	:45 a.m., the					
		e person indicated					
	the lift had l	been sent to a					
	welding con	npany in order to					
	have the ma	st straighten. The					
	maintenance	e person indicated					
	the lift had l	been returned to the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		A. BU	ILDING	00	COMPI 04/18/2	LETED	
		102201	B. WI		DDRESS, CITY, STATE, ZIP CODE	0-7/10/2	
NAME OF I	PROVIDER OR SUPPLIER				EVENTH ST		
GOSPOF	RT NURSING HOME	≣		GOSPO	DRT, IN47433		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	facility on 2/	/11/11. The					
	maintenance	supervisor					
	indicated he	checked the					
	mechanical l	lifts at least two					
	times a mon	th, checking and					
	tightening bo	olts and lubricating					
	as needed.						
	During inter	view of the DON					
	on 4/6/11 at	11 a.m., the DON					
		e mast of the lift					
	was just ben	t a little bit. The					
	l	ted she was not					
		as done to the lift					
		at, but she and the					
		ld it was ok to use					
	the lift, when						
	ĺ	he facility. The					
		ted the facility had					
		•					
	a Hoyer and						
		lift and the lifts had					
		terchangeably for					
		eding a mechanical					
	lift.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00		(X3) DATE : COMPL	
15E281			A. BUII B. WIN				04/18/2	
NAME OF I	PROVIDER OR SUPPLIER	!! }	1		DDRESS, CITY, STATI	E, ZIP CODE		
	RT NURSING HOM				VENTH ST RT, IN47433			
(X4) ID		STATEMENT OF DEFICIENCIES		ID I	·			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED	TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICI	IENCY)		DATE
		t 11:15 a.m., the						
	1 ^	led a list of 11						
		mes, that required a						
		lift for transfers,						
		ave used either the						
	Hoyer Lift o	or the Invacare Lift						
	since the lift	t was returned to						
	the facility of	on 2/22/11. During						
	interview at	that time, The						
	DON indica	ted there had not						
	been any oth	ner incidents with						
	the lift after	the lift was						
	returned to t	he facility on						
		il $4/3/11$, when the						
	1	ver during the						
	1 **	Resident #21. The						
		ted Resident #21						
	had not beer							
	ina not occi	ju: vu.						
	 During revie	ew of Resident						
		al record, a nurse's						
	l	4/3/11, at 3:15 p.m.,						
		ring a transfer of						
		the mechanical lift						
	uppea over.	Documentation						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	TOKX11	Facility II	D: 000409	If continuation sl	neet Pa	ge 75 of 102

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281		(X2) MUI A. BUILD B. WING	DING	00	(X3) DATE: COMPI 04/18/2	ETED	
	PROVIDER OR SUPPLIEF			27 S SE	DDRESS, CITY, STATE, ZIP CODE VENTH ST PRT, IN47433		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU		Denies hitting head,		IAU			DATE
	denies any p	ain or discomfort					
	just scared. smoke."	Wants to go					
	not limited to behaviors and (cerebral vast with left side 2. On 4/4/1 4/6/11 at 4:4 #34 was sitts	vas noted of, but o, Dementia with nd history of a CVA scular accident) ed hemiplegia. 1 at 12 noon, and 15 p.m., Resident ing in a wheelchair elt restraint. The					
	belt was acre abdomen, ar belt went str the top of th wheelchair, chair back o During revie	oss the resident's and the straps of the raight back, across e arms of the and was tied at the f the wheelchair. ew of "POSEY -					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281		LDING	00	(X3) DATE COMP 04/18/2	LETED
NAME OF I	PROVIDER OR SUPPLIER	₹	•	1	DDRESS, CITY, STATE, ZIP CODI VENTH ST	3	
GOSPO	RT NURSING HOM	E		GOSPC	PRT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	POSEY LA	P BELT/PADDED					
	LAP BELT"	received by the					
	DON on 4/7	7/11 at 10:40 a.m.,					
	documentati	on indicated "1.					
	Lay the belt	across the patient's					
	lap, foam sid	de down. 2. Bring					
	the strap end	ds with loops down					
	over the thig	ghs between the					
	seat and the	wheelchair skirt					
	guard. 3. G	o around the back					
	post and cro	ss the straps behind					
	the patient.	Secure the loops					
	on the whee	lchair tilt levers.					
	The Belt sho	ould be over the					
	patient's hip	at a 45 degree					
	angle holdin	g the hips against					
	the back of	the chair"					
	3. On 4/5/1	1 at 10:45 a.m.,					
	CNA's # 4 a	nd 5 transferred					
	Resident #4	2 from the bed to a					
	geri-chair ut	ilizing a Hoyer					
	mechanical	lift. Prior to the					
	transfer the	staff did not lock					
	the wheels o	of the geri-chair and					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 04/18/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	RT NURSING HOM			1	EVENTH ST DRT, IN47433		
(X4) ID		TATEMENT OF DEFICIENCIES		ID 1			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	oting to lower the					
		the geri-chair, the					
	geri-chair ro	lled backward.					
	During revie	ew of "How to use					
	a Hoyer Lift	/ Proper use of					
	Hoyer Lift/H	Hoyer Lift Safety					
	Instruction"	on 4/7/11 at 10:35					
	a.m., provio	led by the DON,					
	documentati	on indicated					
	l	ing handles and					
	1 *	away from the bed.					
		at into position over					
	1 ^	heelchair. Make					
		hair brakes are on."					
	Sure wheelch	nan brakes are on.					
	4. On 4/5/11 at :	3:15 p.m., CNAs #7 and					
		d to transfer Resident #41					
		wheelchair with the					
		450 mechanical lift. The ras positioned under the					
		d the lift sling attached to					
		dent was raised several					
		surface of the bed. With					
		e raised position, the mast, the base was					
	^ ^	m the bed and transferred					
	to the other side	of the room. The base of					
	the lift was open	ed around the resident's					

PRINTED: 05/23/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281	(X2) MULTIPLE CC A. BUILDING B. WING	00	ì	TE SURVEY IPLETED 8/2011
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP O EVENTH ST DRT, IN47433	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	wheelchair, and the chair.	the resident lowered into				
	for the Invacare 12:30 p.m. indicate 2:30 p.m. indicate "ONLY operate MAXIMUM OP LOCKED in place be locked in the for stability and pand transferring a moving the patient turn patient so the operating the lift DOWN button (accontrol valve (mapatient so that his the lift, straddling lower center of g	anufacturer's guidelines Reliant 450 on 4/08/11 at red the following: e this lift with the legs in EN POSITION and ce. The base legs MUST open position at all times patient safety when lifting a patient5. When nt lift away from the bed, at he/she faces assistant procedure. 6. Press the electric) or open the anual/hydraulic) lowering s feet rest on the base of g the mastNOTE: The gravity provides stability nt feel more secure and move.				

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E281			(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/18/2	ETED
	PROVIDER OR SUPPLIER		p. (11)	STREET A	ADDRESS, CITY, STATE, ZIP CODE EVENTH ST DRT, IN47433		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	re .	(X5) COMPLETION
	(EACH DEFICIENCE REGULATORY OR The facility must deprocedures that ere (i) Before offering each resident, or the benefits and point in the benefits and or been immunization or the presentative has immunization; and (iv) The resident or the following: (A) That the resident or the benefit in the benefit	evelop policies and asure that the influenza immunization, the resident's legal eves education regarding obtential side effects of the soffered an influenza when 1 through March 31 the immunization is medically the resident has already the resident's legal even the even			(EACH CORRECTIVE ACTION SHOULD BE	TE	
	immunization; and	the opportunity to refuse medical record includes					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLET					
AND PLAN	OF CORRECTION	15E281	A. BUIL			04/18/2	
		.0==0.	B. WING		ADDRESS, CITY, STATE, ZIP CODE	0 11 1012	
NAME OF I	PROVIDER OR SUPPLIER				EVENTH ST		
GOSPOR	RT NURSING HOME	Ē		GOSPC	DRT, IN47433		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	documentation that the following: (A) That the resid representative was regarding the bene effects of pneumoc (B) That the resid pneumococcal impreceive the pneum to medical contrain (v) As an alternative assessment and precommendation, immunization may following the first primmunization, unlecontraindicated or resident's legal representative education of offering the immunization of offering the immunization resident's clinic luded doct the resident alegal representative and precommendation, in the second immunization of the immunization of offering the immunization of offering the immunization resident's clinic luded doct the resident alegal representative and provided the Influenza immunization immunization and precommendation of the resident alegal representative and provided the Influenza immunization immunization and provided the Influenza immunization immunization and precommendation are precommendation.	ractitioner a second pneumococcal be given after 5 years pneumococcal ess medically the resident or the presentative refuses the ion. cord review and the facility failed to sidents and/or legal wes were provided The benefits before influenza on and 2) each	F0	334	The correction action accomplished for this deficie is that a new form will be developed that will include the benefits of receiving the flu vaccine and will be maintained the chart of each resident in facility after signing by the resident or representative ye before the flu vaccine is give each year. Residents having potential to be affected by the deficient practice include all residents of the facility. Steps be taken to correct the deficient practice are that a new form be developed or located that have not only the adverse reactions of receiving the flu vaccine, but also the benefits receiving the vaccine. The formal is desired.	ed on the arly n the e to ent will will s of orm	DATE 05/18/2011

j		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15E281	B. WIN			04/18/2011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
COSPOR	RT NURSING HOME	<u>=</u>			EVENTH ST DRT, IN47433	
					JK1, IN47433	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
		l as receiving or			before the flu season begins vaccines are administered.	and
	refusing the	influenza			Should a representative not	
	immunization. [Resident #s' 18,				return the form in a timely manner, the DON or designe	e l
		1, 27, 14, 3, and			shall call the representative a	•
		1, 27, 11, 5, and			document a verbal agreemen	
	40]				refusal for the flu vaccine.The DON shall be responsible for	
					monitoring the system.	
	Findings inc	lude:			Permission forms shall be se	,
	C				out in Aug/Sept of each year DON or designee shall revie	•
	1 D 11 4	101 1' ' 1 1			each chart for the signed for	
	1. Resident	18's clinical record			before the flu vaccine is	
	was reviewe	d on 4/4/11 at 2:15			administered.	
	p.m.					
	1					
	Documentat	ion indicated the				
		eived a influenza				
	vaccine on 1	1/10/10.				
	Information	regarding the				
	benefits of in					
	ımmunizatio	on was lacking.				
	2. Resident	#42 's clinical				
	record was r	eviewed on 4/6/11				
	at 10:25 a.m					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE: COMPL 04/18/2	ETED	
	PROVIDER OR SUPPLIER			27 S SE	DDRESS, CITY, STATE, ZIP CODE EVENTH ST DRT, IN47433	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Documentat	ion indicated the					
	resident rece	eived a influenza					
	vaccine on 1	1/10/10.					
	benefits of in	regarding the nfluenza on was lacking.					
		#15's clinical eviewed on 4/7/11					
		ion indicated the eived a influenza 1/10/10.					
	benefits of in	regarding the of luenza on was lacking.					
		#30's clinical eviewed on 4/7/11					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED
	PROVIDER OR SUPPLIER			STREET A	ODDRESS, CITY, STATE, ZIP CODE EVENTH ST ORT, IN47433	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Documentat	ion indicated the					
	resident rece	eived a influenza					
	vaccine on 1	1/10/10.					
	benefits of in	regarding the nfluenza n was lacking.					
	reviewed on 4/6/Documentation of receiving the flu Documentation of representative be benefits of the in well as documen	vas noted of the resident vaccine on 11/10/11.					
	reviewed on 4/8/Documentation of receiving the flu Documentation of representative behaviors of the in well as documentation of the incomplete the second of the secon	vas noted of the resident vaccine on 11/10/11.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		A. BUI	LDING	NSTRUCTION 00	I i	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE EVENTH ST PRT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	7. Resident #	#14's clinical					
	record was r	eviewed on 4/7/11					
	at 12:15 p.m	. Documentation					
	was noted of	f the resident					
	receiving the	e flu vaccine on					
	11/10/11. D	ocumentation of					
	the resident	or representative					
	being made	aware of the					
	benefits of the	ne influenza					
	immunizatio	n as well as					
	documentati	on of the benefits					
	being mainta	ained on the					
	medical reco	ord was lacking.					
		#3's clinical record d on 4/4/11 at 2:30					
l							
	-	nentation was noted					
	vaccine on 1	nt receiving the flu					
		ion of the resident					
		ative being made					
	•	benefits of the					
		munization as well					
	as document						
	ochemis bem	ng maintained on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		A. BUII	LDING	NSTRUCTION 00		DATE SURVEY COMPLETED 1/18/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP COE VENTH ST PRT, IN47433	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	the medical at 19. Resident at 11:45 a.m was noted of receiving the 11/10/11. Duthe resident abeing made abenefits of the immunization documentation being maintain medical recommendation of the DON with the properties of the pro	record was lacking. #40's clinical eviewed on 4/8/11 Documentation of the resident e flu vaccine on ocumentation of or representative aware of the ne influenza on as well as on of the benefits ained on the ord was lacking. as interviewed on 0 p.m. The DON e information e benefits of the munizations had vided to the their		1	CROSS-REFERENCED TO THE APP		

STATEMENT OF DEFICIENCIES (X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED	
		15E281	B. WING			04/18/2	011
	ROVIDER OR SUPPLIER		!	27 S SE	DDRESS, CITY, STATE, ZIP CODE VENTH ST ORT, IN47433		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	īE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0365 SS=D	Each resident receprovides food prepmeet individual nerosidents reception and the facility for the facility for 1 of 2 residents requiring this swallowing the resident different corrand drink. (Finding including observable)	eives and the facility pared in a form designed to leds. servation, designed to record review, failed to ensure reived food meet their needs reived designed to ensure reived food meet their needs reived food ckener due to problems, in that was receiving resistencies of food Resident #42) udes:	F0:	365	The corrective action accomplished for this deficient will be inservicing of nursing on different thickened consistencies: honey, nectar and pudding. Those residents identified as having the poter to be affected by the deficient practice are those residents an order for thickener. (4) The steps to ensure this deficient practice does not occur agair include: inservicing nursing son difference of thickened liq honey, nectar, and pudding, how much thickener to use for each type of thickened liquids. Orders for these 4 residents have been reviewe and the consistency of the thickened liquids has been addressed in the orders, diet tray cards, and care plans. The charge nurses and DON will observe at mealtime for the	staff r, s ntial t with e n, staff uids: and or d	05/18/2011
	11:40 p.m., 0	CNA #4 was			correct consistency of the	.4:	
	feeding and	providing fluids to			thickened fluids. Documenta will be made on a flow sheet		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE SU COMPLE		
111,2 12,111	or condition	15E281	A. BUI B. WIN	LDING IG		04/18/20	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
GOSPOF	RT NURSING HOME	≣		1	EVENTH ST DRT, IN47433		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG	Resident #42. The resident			IAG	each resident. Observations	will	DATE
		ureed diet. Two			be done at lunch and supper daily times 2 months, weekly for 2		
	_	cups, half full of a			months, then monthly for 2		
		nce, were noted on			months.		
		CNA #4 was					
		be sprinkling the					
		nce in the meat					
	puree, and p						
	1	he resident's water.					
		dietary card on the					
		licated "thickener",					
	but did not s	ŕ					
	consistency.	•					
	During inter	view with CNA #4					
		11:40 a.m., the					
		ed the substance in					
	the medicati	on cup was					
		The CNA indicated					
		just needs a little					
	·	The resident's water					
		d to be given to the					
		n a glass and the					
		able to swallow					
	the liquid. T	The liquid appeared					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MULT A. BUILDI B. WING		00	(X3) DATE S COMPL 04/18/2	ETED	
	PROVIDER OR SUPPLIER		2	27 S SE	DDRESS, CITY, STATE, ZIP CODE VENTH ST RT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		The CNA was					
		pe of consistency					
	the resident's	s fluids were to be.					
	On 4/6/11 at	4:45 p.m., CNA					
	#16 was feed	ding Resident #42.					
	The resident	's fluids were					
	observed to	be very thick and					
	the resident	was spoon fed the					
	liquids.						
	on 4/6/11 at CNA indicate 1/2 full med thickener. To she put the triglasses of fluinable to ide thickened lickened licke	2's clinical record					
	was reviewe	d on 4/6/11 at					
	10:25 a.m.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE S COMPL 04/18/2	ETED	
	PROVIDER OR SUPPLIER			27 S SE	DDRESS, CITY, STATE, ZIP CODE EVENTH ST PRT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	- 1	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	update order 4/1/11. A physician "Pureed NCS sweets], Horliquids." A plan of car an onset date a target date indicating "AD/T [due to] /swallowing approach of ordered-pure thickened lice. On 4/7/11 at (Director of information)	re was noted, with e of 10/18/07, with of 3/20/11, At risk for choking chewing problems, with an "Diet as eed diet with quids." 2 p.m., the DON Nursing) provided concerning the ICK IT" used by					

Facility ID:

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		A. BUI	LDING	00 	COMPI 04/18/2	LETED	
		102201	B. WIN		DDRESS, CITY, STATE, ZIP CODE	0 17 1072	
NAME OF I	PROVIDER OR SUPPLIE	₹		1	EVENTH ST		
GOSPO	RT NURSING HOM	E		GOSPC	PRT, IN47433		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	documentati	ion indicated for					
	"Honey-Lik	e" thickness, based					
	on a 4 oz sir	ngle serving, that					
	3-5 tsp [teas	poons] should be					
	added. Furt	her documentation					
	indicated the	e thickener would					
	thicken a va	riety of hot or cold					
	liquids to th	e viscosity					
	standards of	the National					
	Dysphasia I	Diet and the natural					
	viscosity of	the liquid being					
	thickened an	nd its serving					
	temperature	impact the amount					
	of Thick-it I	Food Thickener					
	required.						
	During inter	view of the DON					
	on 4/7/11 at	2:00 p.m., the					
	DON indica	ted when an order					
	is received f	for a change in the					
	resident's di	et, the dietary					
	department	receives the					
	information	. The DON					
	indicated the	e dietary					
	department	sends out thickener					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
		to utilize if the nires thickener.					
F0367 SS=D	attending physicial Based on obinterview, are the facility for thickened light residents revort of 12 with the had a physic thickened for Finding including including the dining roughly for the dining roughl	servation, and record review, ailed to ensure quids for 1 of 2 riewed in a sample sickened liquids ian's order for the rm. [Resident #3]	FO	367	The corrective action accomplished for this reside that physician was notified a order was received for pude thickened liquids. Resident's identified as having the pote to be affected by the same deficiency are all residents facility. The steps taken to p the deficiency from occuring again is that on Aprl 28 and the DON audited all resider physician orders for missing incorrect orders. The physical was notified of any incorrect missing orders and orders to obtained. DON will be responsible or monitoring the orders for correct/missing orders mon when the new orders arrive the coming month and will reduce the monthly QA meeting.	and ling cential of the revent 2 29, t 3 or cian t or vere nsible thly for notify will	05/18/2011

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		15E281	A. BUII B. WIN			04/18/2	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	!	
GOSPOF	RT NURSING HOME	<u> </u>			EVENTH ST DRT, IN47433		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ТЕ	COMPLETION DATE
IAU		thickener was		IAG			DATE
		the resident's meal					
		12 indicated one					
		nickener was put					
		e juice and one					
	half into the	·					
	On 4/6/11 at	5:15 a.m. the					
	DON was in	terviewed and					
	observed the	resident's liquids.					
	The DON in	•					
	resident's liq	uids were					
	thickened to						
	consistency.						
	indicated the	e resident's husband					
	did not want	the resident to					
	have any sw	allow studies and					
	resident had	increased					
	difficulties v	with liquids due to					
		Huntington's					
	Chorea.	~					
	Resident #3'	s clinical record					
	was reviewe	d on 4/4/11 at 2:30					
	p.m. The mo	ost recent					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE: COMPL 04/18/2	ETED	
	PROVIDER OR SUPPLIER		•	27 S SE	DDRESS, CITY, STATE, ZIP CODE		
GOSPOR	RT NURSING HOMI	E		GOSPC	ORT, IN47433		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	1 ^	on, signed by the					
	physician or	n 4/1/11 did not					
	include an o	rder for pudding					
	thickened lic	quids.					
	recent update addressed the "Needs adequated in improcessed in improcessed in improcessed for and monitor choking/aspessmall bites of liquids to purand spoon for the DON with 4/7/11 at 3:1 indicated a processed in the processed	ne problem of quate nutrition to ving weight and lete blood count] included, but were o, "Feed resident for iration, feed in only. Thicken adding consistency eed to resident." as interviewed on 0 p.m. the DON ohysician's order thickened liquids					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281	A. BUILDING B. WING	00	COMP 04/18/2	LETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433						
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE			
	3.1-21(b)								

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281			(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/18/2011
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	0 11 10/20 11
NAME OF I	PROVIDER OR SUPPLIER			EVENTH ST	
GOSPOR	RT NURSING HOME	Ξ	GOSP	ORT, IN47433	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
F0441 SS=D	The facility must e Infection Control F a safe, sanitary an and to help prever	establish and maintain an Program designed to provide and comfortable environment and the development and	mo		BATE
	and to help prever transmission of dis (a) Infection Control The facility must e Program under wh (1) Investigates, coinfections in the fa (2) Decides what pisolation, should bresident; and (3) Maintains a recorrective actions (b) Preventing Spr (1) When the Infective determines that a prevent the spread must isolate the re (2) The facility must communicable dis lesions from direct their food, if direct disease. (3) The facility must hands after each control to the service of the	and the development and sease and infection. For Program establish an Infection Control mich it - controls, and prevents icility; procedures, such as a paplied to an individual cord of incidents and related to infections. Fead of Infection control Program resident needs isolation to do f infection, the facility esident. Set prohibit employees with a lease or infected skin at contact with residents or contact will transmit the set require staff to wash their direct resident contact for ing is indicated by accepted			
	Personnel must hat transport linens so infection.	andle, store, process and as to prevent the spread of			
	Based on ob	servation and	F0441	The corrective action accomplished for those resid	ents 05/18/2011
	record review, the facility failed to ensure hand hygiene found to have been aff the deficient practice in inservicing of staff on		found to have been affected the deficient practice include:	by	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E281		A. BUIL	LDING	NSTRUCTION 00	(X3) DATE: COMPL 04/18/2	ETED	
NAME OF PROVIDER OR SUPPLIER GOSPORT NURSING HOME			B. WING O4716/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) SERVATIONS OF		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) control.All residents of the fa	cility	(X5) COMPLETION DATE
	urinary cather [Resident #4 observation care [Reside CNAs #1, #7 remove glov contaminated before touch sample of 12 Findings inc. 1. On 4/5/11 CNAs #1 and to provide in Resident #3. gloves, the Coresidents soit slacks. CNA wash cloth with multiple use cleansed the	eter handling [1]; and 1 of 1 [2] of incontinence [3] in that [4], and #8 failed to [6] es after handling [6] d services and [7] in that [7] and #8 failed to [8] es after handling [8] d services and [9] in that [9] es after handling [9] d services and [9] es after handling [9] es after			have the potential to be affect by the same deficient pract6ice. Measures put into to ensure that the deficient practice does not recur incluinservicing of staff with a demonstration of handwashing/infection contropractices for nursing staff. The corrective action will be mone by the charge nurses and DO with daily observations for 30 days of handwashing technic DON will alos monitor the infection control log monthly increase of infections to residents. Findings will be reviewed at the monthly QA meetings.	place de ol ee itored ON ol ques.	
	the resident	to sit in a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 15E281	A. BUI	LDING	00		COMPL 04/18/2	ETED
	13E201		B. WIN		DDDEGG CIER CE.	TE ZIN CODE	04/10/2	U 1 I
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STA	I E, ZIP CODE		
	RT NURSING HOMI			GOSPORT, IN47433				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCE DEFI	ED TO THE APPROPRIATI ICIENCY)	E	DATE
	wheelchair.	The CNA, while						
	wearing the	same gloves, wet						
	another was	h cloth, picking up						
	the bottle of	cleanser assisted						
	the resident	to stand and						
	cleansed the	resident's						
	buttocks. C	NA #1 then picked						
	up a multiple	e use tube of						
	barrier crean	n, while wearing						
	the same glo	ves, and applied						
	the cream to	the resident's						
	buttocks. Tl	ne CNA then						
	assisted in p	ulling up a clean						
	brief and sla	cks, removed the						
	gloves and p	ositioned a lap						
	buddy to the resident's							
	_	CNA #1 picked up						
		ream and bottle of						
		er, exited the room,						
		tems into the dining						
		West nursing unit,						
		utility room with						
	the items.	<i>a</i> 100:11 With						
	the realis.							
	2. On 4/5/11	1 at 3:15 p.m.,						
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:				Facility I	D: 000409	If continuation sh	eet Pa	ge 98 of 102

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED				
15E281			A. BUI B. WIN			04/18/20		
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE	l		
GOSPORT NURSING HOME				1	EVENTH ST DRT, IN47433			
(X4) ID				ID I		1	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	1	DATE	
	CNAs #7 and #8 were observed to provide ADL (activities of							
	•	`						
		care to Resident						
	#41. The res							
		bed and to have a						
	Foley cathet							
	wearing glov	ŕ						
	•	e urinary drainage						
	<u> </u>	the catheter						
	U .	the drainage bag on						
		s bed, opened the						
		adjusted the						
		ds in the resident's						
	room, without washing hands.							
	_	s policy titled						
	"Handwashing Procedure," [no date] provided by the DON on 4/7/11 at 10:35 a.m., included but was not limited to:							
	"Handwashi	ng is the single						
	most important means of preventing the spread of							
	infection!	Hands are to be						
	washed: 3.	After handling						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		00	(X3) DATE S COMPL				
15E281		15F281	B. WING			04/18/2	011		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
GOSPORT NURSING HOME			27 S SEVENTH ST GOSPORT, IN47433						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)]	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		Έ	(X5) COMPLETION DATE		
	bedpans, catheters, linens, etcThe purpose of handwashing								
	remove pote organisms. can have ma sources; organisms. infected urduring routing catheter bag on the next respectively.	•							
F0456 SS=D	The facility must m mechanical, electrequipment in safe Based on obtainterview, the	naintain all essential ical, and patient care operating condition. servation and ne facility failed to ent equipment was in that 2 of 2	F04	456	The corrective action accomplished for this deficier is that 2 new geri-chairs and buddies will be ordered to repute damaged ones. Those residents having the potentia be affected by the deficient practice are identified as those residents who use a geri-chair	3 lap olace I to	05/18/2011		

		X1) PROVIDER/SUPPLIER/CLIA		MULTIPLE CO		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. B	UILDING	00	COMPLETED			
	15E281		В. W	ING	DDDDGG GYMY GW == == == == == == == == == == == == ==	04/18/2011			
NAME OF I	PROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST					
GOSPO	RT NURSING HOMI	E		GOSPORT, IN47433					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)				
TAG		arved ware oither		TAG	lap buddy.Measures put into	DATE			
		erved were either			place to ensure the deficient				
	**	d bent frames.			practice does not recur is sta be inserviced on monitoring	ìπ Will			
	[Kesidents #	⁴ 9, #42, and #8]			geri-chairs and lap buddies f				
					wear and damage and how t report to maintenance if repa				
	Findings inc	clude:			are needed. Maintenance w	ill			
					inspect geri-chairs weekly ar document findings and repor	l l			
	1. During e	nvironmental tour			administrator when				
	with the Ma	intenance staff #15			repairs/replacements are needed.Administrator will be				
	on 4/8/11 at				responsible for geri-chair	N will			
		's geri-chair was			replacement/repairs and DO be responsible for replacement	l l			
		th a crooked foot			damaged lap buddies				
		aintenance person							
		er the chair and							
		view at that time,							
	l	e metal frame to the							
	foot rest was	s bent. On 4/4/11 at							
	12:00 p.m.,	Resident #9 was							
	observed in	the chair, in the							
	dining room, and for the								
	footrest to be slanting to the								
	right.	C							
	<i>S</i>								
	2. During of	bservation of care							
	on 4/5/11 at 10:20 p.m.,								
	l	2 was placed in a							
FORM CMS-2	2567(02-99) Previous Version	*	TOKX ²	11 Facility I	D: 000409 If continuation s	heet Page 101 of 102			

AND PLAN OF CORRECTION IDENTIFY		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E281		LDING G	NSTRUCTION 00	(X3) DATE: COMPL 04/18/2	ETED		
NAME OF PROVIDER OR SUPPLIER GOSPORT NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	geri-chair.	The foot rest of the							
	chair was ob	served to be							
	crooked and	when in a down							
	position wou	ald not close all the							
	_	nyl was torn on							
		of the seat cushion,							
		white foam interior.							
	_	was noted on the							
	interior back	t base of the							
	geri-chair.								
	Resident #8 wheelchair v across her al covering of observed wi	1 at 11:20 a.m., was in a with a lap buddy odomen. The vinyl the lap buddy was th three torn areas white foam interior.							